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COMMUNITY HEALTH PLAN
HEALTHY FAMILIES PROGRAM

Frequently Called Numbers/Números para llamadas frecuentes

Healthy Families Program: Family Contribution/Contribución familiar 1 (800) 880-5305

24-Hour Medical Advice Service/Servicio de consejos médicos las 24-horas
Community Health Plan ..... 1 (800) 832 - MEDI *or* 1 (800) 832-6334

24-Hour Nurse Advice Line/Línea de consejos de enfermería las 24-horas
Universal Care 1 (800) 377-7012

Member Services Department/Departamento de Servicios para Miembros
Community Health Plan 1 (800) 475-5550
Universal Care 1 (800) 635-6668
TDD Service ..... 1 (626) 299-7265 & 7266

Medical Administration Department/Departamento de Administración Médica
Community Health Plan 1 (626) 299-5539

California Children Services 1 (626) 858-2100

California Department of Managed Health Care 1 (888) 466-2219

EMERGENCY/EMERGENCIA 911

HFP EOC Revision 13
05/01/2002

BENEFIT YEAR 2002-2003

WELCOME TO COMMUNITY HEALTH PLAN'S HEALTHY FAMILIES PROGRAM

Thank you for choosing Community Health Plan (Plan). Please review the information in this guidebook carefully. The information will help you use the Plan's medical services effectively.

Your medical care will be provided by a qualified, health care professional in one of our doctor offices, clinics or hospitals. Your Primary Care Provider will work with other doctors in all major specialties, pharmacists, nurses and other health professionals to ensure that you receive the best health care.

If you have any questions or comments about the Community Health Plan or would like additional information about Healthy Families Program and Community Health Plan benefits, please contact a Plan Representative at the Plan clinic/doctor office where you have chosen to receive your medical care (refer to the Community Health Plan Provider Directory), or you may write or call us at:

Community Health Plan
Member Services Department
1000 South Fremont Avenue
Building A-9 East, 2nd Floor, Unit #4
Alhambra, CA 91803-1323
1 (800) 475-5550
TDD Service: 1 (626) 299-7265 & 7266

We will be glad to answer your questions and listen to your comments.

This Combined Evidence of Coverage and Disclosure form constitutes only a summary of health plan benefits. The health plan contract must be consulted to determine the exact terms and conditions of coverage. In the event of a conflict between the contract and the Combined Evidence of Coverage and Disclosure, the provisions of the Combined Evidence of Coverage and Disclosure shall be binding upon the Plan notwithstanding any provisions in the contract, which may be less favorable to subscribers. The Plan Contract is available upon request by calling 1 (800) 475-5550. The Health Plan Benefits Summary is on page 3. This Combined Evidence of Coverage and Disclosure discloses the terms and conditions of coverage. You have a right to review it before you enroll in the Community Health Plan.

PLEASE READ THE FOLLOWING INFORMATION COMPLETELY AND CAREFULLY SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED. IF YOU AVE SPECIAL HEALTH CARE NEEDS, PLEASE READ CAREFULLY THOSE SECTIONS THAT APPLY TO YOUR HEALTH CARE NEEDS.

ELIGIBILITY AND ENROLLMENT

Information on eligibility enrollment, open enrollment, disenrollment, the starting date of coverage, transfers to another health plan, annual requalification, premium payments, the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), and cost sharing waiver for American Indians/Alaska Natives is included in the Healthy Families Program Handbook which was sent to you by the program. If you have questions on these topics or would like another copy of these materials, please contact the Healthy Families Program at:

Healthy Families Program
P.O. Box 138005
Sacramento, California 95813-8005
1 (800) 880-5305

CUSTOMER SERVICE

The Community Health Plan, Plan providers, and staff at your primary care clinic/doctor office want to ensure that you receive the best health care possible, and that you receive all the assistance and information that you may need. If you speak a language other than English, we have interpreters available 24 hours who speak your language. Our interpreters will assist you and provide you with information whenever you call the Plan, including when you call the Member Services Department (1-800-475-5550), After-Hours Medical Advice Service (1-800-832-MEDI or 1-800-832-6334), or visit any of the Plan providers for care. (Currently, the Plan's interpreter services are supplemented by the AT&T Language Line interpreters.)

HEALTH PLAN BENEFITS SUMMARY

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Following is a summary of covered services, pursuant to Program health benefits. Please refer to the "Health Plan Benefits" and "Exclusions and Limitations" sections of this guidebook for additional information. Healthy Families Program has no deductibles nor lifetime maximums.

BENEFITS	**COPAYMENTS SUBSCRIBER PAYS**	**LIMITATIONS**
Professional Services		
Office Visits	$5/Visit	
Home Visits	$5/Visit	
Allergy Tests and Treatment	$5/Visit	
Radiation/Chemotherapy/Dialysis	No Copayment	
Inpatient Hospital Services	No Copayment	
Surgery/Anesthesia	No Copayment	
Physical/Occupational/Speech Therapy	$5/Visit	
Outpatient Services		
Office Visits	$5/Visit	
Preventive Care (Includes Office Visits for Preventive Care, Immunizations, Periodic Health Examinations, Well Baby Care, Prenatal Care, STD Tests, and Cytology Examinations)	No Copayment	Well baby care is provided during the first 2 years of life for infants.
Hospital Outpatient Services	No Copayment	
Family Planning Services	No Copayment	
Prenatal/Maternity Care	No Copayment	
Physical, Occupational, and Speech Therapy (Includes Home Health Care)	$5/Visit	
Hearing Tests and Hearing Aids	No Copayment	
Eye Examinations	No Copayment	

BENEFITS	COPAYMENTS SUBSCRIBER PAYS	LIMITATIONS
Cataract Spectacles and Lenses	No Copayment	As medically necessary after cataract surgery
Outpatient Services (continued)		
Eyeglasses/Contact Lenses	No Copayment	As medically necessary after cataract surgery
Abortion Services (Includes elective abortions)	No Copayment	Not over 24 weeks gestational age
Hospitalization Services		
Acute Care	No Copayment	
Intermediate Care	No Copayment	
Skilled Nursing Care	No Copayment	100 Days/Benefit Year
Emergency Health Care	$5/Visit $5/Visit for non-emergent outpatient care	
Ambulance Services	No Copayment	
Prescription Drugs		
Inpatient (Includes inpatient drugs and drugs administered in a doctor's office)	No Copayment	Excludes experimental or investigational drugs which are not recognized in accordance with generally accepted medical standards as being safe and effective
Mental Health		
Outpatient	$5/prescription	
Tobacco Cessation	$5/prescription	Subscriber must attend Plan's Tobacco Cessation Classes
FDA Approved Contraceptives and Devices	No Copayment	
Durable Medical Equipment	No Copayment	
Mental Health		
Inpatient Care	No Copayment	30 Days/Benefit Year Seriously Emotionally Disturbed (SED) and Severe Mental Illness (SMI) are not limited.
Outpatient Care	$5/Visit	20 Visits/Benefit Year; Plan May Provide

BENEFITS	COPAYMENTS SUBSCRIBER PAYS	LIMITATIONS
		Additional Visits Seriously Emotionally Disturbed (SED) and Severe Mental Illness (SMI) are not limited.
Chemical Dependency Services		
Inpatient Care	No Copayment	As medically necessary to remove toxic substances from the system
Chemical Dependency Services		
Outpatient Care	$5/Visit	20 Visits/Benefit Year; additional visits as medically necessary
Home Health Services	No Copayment	
Medical Transportation	No Copayment	
Blood and Blood Products	No Copayment	
Diagnostic X-ray and Laboratory Services	No Copayment	
Hospice Care	No Copayment	For diagnosed terminal illness with one (1) year life expectancy.
Orthotics and Prosthetics	No Copayment	
Health Education	No Copayment	

ACCESSING CARE

Choosing a Physician

It is important that you choose your Primary Care Provider. If you do not choose a Primary Care Provider at the time of enrollment, a Primary Care Provider will be assigned to you to make sure that all your health care needs are met. When the Community Health Plan selects a Primary Care Provider for you, the Plan makes sure that eligible family members are assigned to the same provider, the location of the primary care clinic/doctor office is in your zip code or within a ten (10) mile radius from your home, the provider does not have more patients than allowed by the Plan so that you can get an appointment within a reasonable time, and the provider meets your language and health care needs. Also, your age and gender are taken into consideration when the Plan assigns your provider.

You always have the right to select a provider close to your home. If you would like to change providers, contact your Primary Care Provider or the Plan's Member Services Department at 1 (800) 475-5550.

Community Health Plan Subscribers receive their regular health care from the Plan Primary Care Provider, clinic or doctor's office they have selected or been assigned. Your Primary Care Provider will:

- Provide primary health care, and coordinate other health care, except in an emergency.
- Provide "well care," including physical examinations.
- Provide prescriptions for medicine and medical supplies.

Your Primary Care Provider will refer you to a specialist, hospital, intermediate (sub-acute and transitional inpatient) care facility, or skilled nursing facility affiliated with the primary care site/provider, as medically necessary. Your Primary Care Provider must authorize services, except in an emergency.

Facilities and Provider Locations

Included in your new Subscriber packets are our Community Health Plan Provider and Pharmacy Directories. These guides list the addresses, telephone numbers and hours of service of our health care providers and pharmacies. Keep these guides handy and refer to them when you need to access care. To obtain a list of the Plan's affiliated intermediate (sub-acute and transitional inpatient) care facilities, you may contact the Member Services Department at 1 (800) 475-5550.

Changing Medical Groups and Primary Care Physicians/Providers

Subscribers may change their Community Health Plan primary care site or provider on a monthly basis. If you would like to transfer to another medical group and Primary Care Provider, please

contact your Primary Care Provider at the clinic/doctor office where you receive your regular health care or the Plan's Member Services Department at 1 (800) 475-5550.

Continuity of Care

At the time you enrolled in our Plan, you may have received health care treatments from a doctor who is not a Community Health Plan doctor. Your Primary Care Provider will help decide if you should continue to receive treatment with your previous doctor or with a Community Health Plan doctor. If you want to complete the necessary treatment with a non-affiliated doctor, you should submit a written request to your new Community Health Plan Primary Care Provider. Contact the Plan's Member Services Department at 1 (800) 475-5550 to obtain a copy of the Plan's Continuity of Care Policy.

How to Help Your Primary Care Provider

New Subscribers are encouraged to obtain initial health assessments, follow-up care, and periodic physical examinations, as recommended by their Primary Care Provider. As a new Subscriber, you will be asked to complete an individual assessment form. The assessment will enable the Primary Care Provider to identify and address your health needs. You should make a first appointment within four (4) months or sooner from the date you are enrolled in the Plan. You are encouraged to make and keep appointments for health care and to ensure that all medication is taken, as recommended by the health care provider. You may also ask for health education brochures available at your primary care site.

If You Are Pregnant

If you are pregnant, you can receive comprehensive pregnancy care. It is important to receive care in the first three (3) months of your pregnancy. If you are pregnant or think you are pregnant, call your Plan Primary Care Provider right away.

Scheduling Appointments

To make clinic/doctor office appointments, call the Appointment Clerk at the Plan primary care clinic or doctor office you have chosen to go to for your health care. You should tell the Appointment Clerk that you are a Community Health Plan Subscriber. Have your Plan identification card(s) available. Clinic/doctor appointments are generally available Monday through Friday between 8:00 a.m. and 4:30 p.m. Evening and Saturday clinic/doctor office appointments may be available at some Plan sites. Please see the Provider Directory for more information about each clinic.

If you need medical advice during clinic/doctor office hours, you may call your Primary Care Provider and speak to her/him or a Plan nurse. The Primary Care Provider or Plan nurse will answer your questions and help you decide if you need to come into the clinic/doctor's office.

If you cannot come in for your appointment, you should call as far ahead as possible to let the clinic/doctor's office know. You can schedule another appointment at that time.

Inpatient Services

Community Health Plan provides coverage for acute and intermediate (sub-acute and transitional inpatient), hospice and skilled nursing care. These services require prior authorization from your Primary Care Provider or Case Manager, except in an emergency. Intermediate and skilled nursing facility services are covered for 100 days.

Referrals to Specialists

Specialty services are covered benefits and available only through referral by your Primary Care Provider. These services are available at specialty clinics and doctor offices. Your Primary Care Provider will submit a written referral with prior authorization for you to receive specialty care services. The referral facility will review the referral for appropriateness and complete information, and inform your Primary Care Provider of the decision in writing or by telephone. Your referral request will be processed as follows: a) immediately if referral is emergent; b) within same day if referral is urgent; and c) within five (5) working days if referral is routine. Upon approval, you will be informed of your appointment date to the specialty service facility. If you require Covered Services not available within the Community Health Plan health care network, you will be referred by the Primary Care Provider to another provider for care. The Plan will pay for such services only when you are referred by your Primary Care Provider. If you have a chronic or life threatening illness which requires continuous specialty care, your Primary Care Provider may refer you to a specialist or specialty care center on an extended basis. The specialist or specialty care center will have expertise in treating your specific condition or disease. The specialist and Primary Care Provider will communicate to ensure coordination and continuity of care.

You may receive a "standing referral" to a specialist if your PCP and the specialist determine that you have a condition or disease that require specialized medical care over a prolonged period of time and is life-threatening, degenerative, or disabling.

A subscriber may access the following services inside or outside of CHP network, and prior authorization is not required:

- Family Planning Services;
- Sexually Transmitted Diseases;
- Obstetrical and Gynecological Care (within provider groups network);
- Emergency Services; and
- Abortion services in an outpatient setting.

To get more information about specialists who have expertise in treating special conditions or diseases, you may contact your Medical Group or call Community Health Plan at 1 (800) 475-5550.

American Indian Services

American Indians have the right to receive medical services at Indian Health Clinics. American Indians can access medical services, from Indian Health Clinics without prior referral from Primary Care Providers. For more information regarding how to obtain care at one of these clinics, contact the Plan's Member Services Department at 1 (800) 475-5550.

Direct Access to OB/GYN Care

A subscriber may seek obstetrical (OB) and gynecological (GYN) services directly from an OB/GYN or Family Practice physician listed within the subscriber's chosen Community Health Plan provider group, on an unlimited basis without prior authorization. To ensure continuity of care and coordination of services, the OB/GYN or family practice provider will communicate with your Primary Care Provider regarding your condition, treatment and any need for follow-up care. For more information, contact your Primary Care Provider at the clinic where you obtain care or the Plan's Member Services Department at 1 (800) 475-5550.

Pharmacy Services

You can fill your prescriptions at pharmacies located at the clinic where you receive your regular care, or at County hospitals and health centers, or at Plan contract pharmacies located in your community. To get prescriptions filled, you must show the pharmacist your Plan identification card, and pay the Copayment amount at the time you present the prescription. Pharmacies are listed in the Community Health Plan Pharmacy Directory. A $5.00 Copayment is charged to Subscribers for each prescription medication, except prescription contraceptive drugs and devices.

Plan subscribers and the general public may request a copy of the most current list of medications on the Plan's Drug Formulary by major therapeutic category, whether any drugs on the list are preferred over other listed drugs. Drugs listed on the Drug Formulary do not guarantee that they will be prescribed by your provider.

Drug Formulary

Plan Subscribers and the general public may request a copy of the most current list of medications on the Plan's Drug Formulary by major therapeutic category. The formulary also identifies if a drug on the list is preferred over other listed drugs. Authorization for an off-label use of an FDA approved formulary medication, prescribed by a participating physician for a life-threatening or chronic and seriously debilitating condition, will be approved if your provider provides required documentation supporting medical necessity, safety and efficacy for the intended use. Drugs listed on the Drug Formulary do not guarantee that they will be prescribed by your provider. However, authorization will be provided for a non-formulary medication if your provider demonstrates that no formulary alternative exists and the medication is necessary due to either one of the following conditions:

- Lack of formulary alternative
- Failure to respond to appropriate formulary alternatives

- Documented allergy or adverse reaction to formulary alternative
- Special patient needs requiring a non-formulary medication

Non-Formulary authorization requests will be evaluated on the basis of an individual patient's needs.

If you would like a copy of the Drug Formulary, contact Community Health Plan's Member Services Department at 1 (800) 475-5550.

Prior Authorization Process for Non-Formulary Prescriptions During Office Hours

If your condition requires the use of a drug that is not listed in the Drug Formulary, your doctor or pharmacist is to contact the Community Health Plan Utilization Management Unit for authorization during business hours at 1 (626) 299-5539 or fax the request to 1 (626) 299-7262. The Plan will respond within 24-hours after receiving your provider's request for authorization of a non-formulary drug. There may be instances where the Plan will not be able to process a request for authorization within 24 hours if a requesting physician fails to timely provide pertinent information.

Prior Authorization Process for Non-Formulary Prescriptions After Business Hours, On Weekends and Holidays

The Plan has staff on duty 24 hours a day, 7 days a week, including weekends and holidays, to respond to requests for non-formulary drug authorizations and/or renewals. Your doctor or pharmacist may call for an authorization at 1-800-832-MEDI (1-800-832-6334).

Prescription Authorization Process for Emergent or Urgent Circumstances

If you are out of medication, or there is a failure in the systems used to verify member eligibility and approve a request for authorization, your pharmacist is authorized to dispense to you a supply of medication for up to three (3) days or 72 hours.

Reimbursement Provisions

If you receive a bill or claim from a hospital or provider which provided medical services, from a store which provided medical supplies, or from an affiliated pharmacy that erroneously charged you for medication, or from an ambulance company, mail the original itemized bill and receipt (if applicable) to the address below within 60 days of the date services were received:

Community Health Plan
1000 South Fremont Avenue
Building A-9 East, 2nd Floor, Unit #4
Alhambra, CA 91803-1323
Attention: Finance Division

Upon receipt of the claim or bill, the Plan Administrative Office will determine if the services provided are covered by the Community Health Plan.

Claims for Out-of-Plan emergency or ambulance services will be considered for payment only if:

- The Plan was notified by you, a family member, attending physician, hospital or other representative within 48 hours of transportation, admission, or treatment, AND

- A request for payment was received by the Plan at the above address within 60 days after the date of the first service for which payment is requested.

All claims are acted upon within 45 working days after all requested information is received. Processing of claims for payment may require obtaining medical records and other information from the non-Plan provider. Claims may be fully paid, partially denied, or completely denied. If partially or completely denied, you will receive a written notice indicating the reason(s) for denial along with the specific contract provisions upon which the denial is based. You will also receive information about procedures for requesting reconsideration of a claim.

The Community Health Plan will reimburse non-Plan providers for authorized services and genuine emergency care only. If non-authorized health care services are obtained on a non-emergent basis from a provider not affiliated with your Primary Care Provider, you may be responsible for payment of the entire bill.

Treatment Authorization

Each primary care site has system to evaluate a request for treatment authorization, including intermediate (sub-acute and transitional inpatient) and skilled nursing care. The request for treatment authorization will be reviewed and a determination will be made for approval as follows: a) immediately if emergent request; b) within the same day if urgent request; and within five (5) working days if routine request. The decision will be communicated in writing or by telephone, as medically necessary. The Primary Care Provider reviews all delayed, modifications, and denials of services. You have the right to appeal or submit a grievance regarding a delayed, modification, or denial of services. You can also obtain further assistance from the California Department of Managed Care at 1 (888) 466-2219. A written appeal or grievance should be submitted to the Primary Care Provider or the Plan's Member Services Department. To obtain a copy of the services authorization policy, contact the Plan's Member Services Department at 1 (800) 475-5550.

How to Obtain a Second Opinion of Your Treatment

Community Health Plan has a policy to address a Subscriber's request for a second medical opinion. You or your provider may initiate the request by contacting the Plan's Medical Administration Department at 1 (626) 299-5539.

Reasons for a second opinion to be provided or authorized will include, but are not limited to, the following:

1. You question the reasonableness or necessity of recommended surgical procedures;

2. You question a diagnosis or plan or care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition;

3. Your medical problem and treatment plan are not clear or are complex and confusing, a diagnosis is not clear due to conflicting test results, or the provider is unable to diagnose the condition, and you request an additional diagnosis;

4. Current treatment is not improving your medical condition within an appropriate period of time, and you request a second opinion regarding the diagnosis or continued treatment; or

5. You have attempted to follow the plan of care or talked with your provider concerning serious concerns you have about the diagnosis or plan of care.

You, or your provider may request a second medical opinion by submitting a request to your Medical Group. To obtain more information about a second medical opinion, you may call or write to the Plan's Member Services Department at:

Community Health Plan
Member Services Department
1000 South Fremont Avenue
Building A-9 East, 2nd Floor, Unit #4
Alhambra, CA 91803-1323
1 (800) 475-5550

For non-urgent request, the decision to approve, modify or deny the request will be communicated to you in writing within 2 business days from the date of receipt. If you have a life threatening condition, or other condition with the potential for significant negative impact on your health if not addressed immediately, a second medical opinion will be rendered to you within 72 hours after the Plan's receipt of the request, whenever possible.

If your request for second medical opinion is about care from your primary care provider, your Primary Care Provider may refer you to a qualified health professional within your assigned medical group who has the appropriate training and expertise to review your treatment plan. If your request for second medical opinion is about care from a specialist, your primary care provider may refer you to a qualified specialist from any Community Health Plan contracted medical group. If there is no provider who meets the standards, your Primary Care Provider may authorize the referral to an out-of-network provider.

Should your request be denied and you remain dissatisfied with the medical group decision, your appeal shall be reviewed by the plan's Medical Director. The Medical Director shall have the authority to make the final decision.

External, Independent Review of Experimental of Investigational Therapies

The Community Health Plan will provide an external, independent review to examine the Plan's coverage decisions regarding experimental or investigational therapies for Subscribers who meet all of the following criteria:

1. The Subscriber has a life-threatening or seriously debilitating condition.

2. The Subscriber's physician certifies that the Subscriber has a life-threatening or seriously debilitating condition for which standard therapies have not been effective in improving the medical condition, or for which standard therapies would not be medically appropriate for Subscriber, or for which there is no more beneficial standard therapy covered by the Plan than the therapy proposed below.

3. Either, the Subscriber's physician has recommended and certifies in writing a drug, device, procedure or other therapy that is likely to be more beneficial to Subscriber than any available standard therapies, or the Subscriber or her/his non-participating qualified provider has requested a therapy that based on medical and scientific evidence is likely to be more beneficial for the Subscriber than any available standard therapy. The physician certification must include a statement of evidence in certifying his or her recommendation.

4. The Subscriber has been denied coverage by the Plan for a drug, device, procedure or other recommended therapy.

5. The treatment or therapy recommended would be a covered service, except for the Plan's determination that the treatment is experimental or investigational.

Within one (1) business day of the decision to deny coverage, the Plan will notify the Subscriber and her or his physician in writing of the opportunity to request the external, independent review. The external, independent review can be requested by calling Community Health Plan's Medical Administration Department at 1 (626) 299-5539 or submitting a written request to:

Community Health Plan - Medical Administration Department
1000 South Fremont Avenue
Building A-9 East, 2nd Floor, Unit #4
Alhambra, CA 91803-1323

The Community Health Plan's Medical Administration will determine if the Subscriber meets **all** of the criteria to have the requested therapy reviewed under the external, independent review process. The review will be performed by an impartial independent review entity that has been accredited by the State of California. The entity will select an independent panel of physicians or other providers who are experts in the treatment of the Subscriber's medical condition and knowledgeable about the recommended treatment. Neither the Community Health Plan nor Subscriber will choose or control the choice of physicians or other provider experts. The cost of the external, independent review will be borne by the Community Health Plan.

The external, independent review panel will render its analysis and recommendation within thirty (30) days of the Community Health Plan's receipt of the Subscriber's request for review. If the

Subscriber's physician determines that the proposed course of treatment or therapy would be significantly less effective if not promptly initiated, the analysis and recommendation will be rendered within seven (7) days of the request for expedited review.

Coverage for the proposed therapy or treatment will be provided subject to the terms and conditions generally applicable to all other benefits under the Community Health Plan. For more information regarding the external, independent review process or coverage under the Community Health Plan, contact our Medical Administration Department at 1 (626) 299-5539.

Continuity of Care With a Terminated Provider for a Subscriber With Acute or Chronic Condition

A Subscriber with an acute and serious, chronic condition, high risk or late term pregnancy may request continuity of care, up to 90 days or more, with a terminated Community Health Plan provider. The Plan will ensure that the Subscriber remains with the terminated provider until a safe transfer to a new Plan partnering provider can be arranged.

A Subscriber may request continuity of care with a terminated provider by contacting the Plan Member Services Department or her/his Primary Care Provider, by telephone or in writing.

After-Hours Medical Advice Service

Community Health Plan has an After-Hours Medical Advice Service staffed by physicians and nurses who are available to assist you with your health care needs. If you need medical advice or think you may need medical attention after normal clinic/doctor office hours, on weekends or holidays, you can call and speak with a Plan physician or nurse on call. They will tell you how to take care of your medical problem at home, or send you to the emergency room, or tell you how and where to access care. The after-hours telephone number is 1-800-832-MEDI (1-800-832-6334).

During regular clinic/doctor office hours, you can contact your Primary Care Provider if you need medical advice or think you need medical attention.

Tobacco Cessation Classes

Community Health Plan provides treatment to help smokers stop smoking. Tobacco cessation medication is a covered benefit and is provided in conjunction with the Subscriber's participation in the Tobacco Cessation Classes. To obtain more information, contact your Primary Care Provider at the clinic/doctor's office where you go to obtain health care, or you may contact the Plan's Medical Administration Department at 1 (626) 299-5539.

Service Area

The Community Health Plan's Service Area includes all of Los Angeles County. If you have questions regarding the Community Health Plan Service Area, please call the Plan's Member Services Department at 1 (800) 475-5550.

EMERGENCY AND URGENT SERVICES DEFINITIONS

Definitions

Emergency Services are provided for members with conditions that are manifested by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention may result in placing the health of the individual or unborn child in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily organ or part. Emergency services also include care for an emergency psychiatric condition.

Urgent Care services are provided to members who present with conditions that have the potential to become an emergency in the absence of treatment.

What To Do When You Require Emergency Services

You are encouraged to appropriately use the "911" emergency response system, in areas where the system is established and operating, when you have an emergency medical condition that requires an emergency response. When receiving emergency services from an ambulance provider or the paramedics, please identify yourself as a Subscriber of the Community Health Plan and show them your Plan identification card. Ambulance transportation in connection with emergency services is covered regardless of whether ordered by a paramedic or Plan provider. If you or an enrolled Subscriber are admitted to a non-Plan hospital, you must notify the Plan within 48 hours of the admission.

Plan benefits cover emergency services in an Out-Of-Plan hospital if it was an emergency as defined in this Combined Evidence of Coverage and Disclosure and the Plan contract (refer to previous page).

How to Get Emergency Transportation

Emergency transportation is available to you when you have an emergency medical condition. If you are not sure if you need emergency transportation, you may call your Primary Care Provider and follow her/his advice or you may call the Plan's 24-hours After-Hours Medical Advice Service at 1 (800) 832-MEDI (1-800-832-6334).

Ambulances for medical emergencies are paid for by Community Health Plan. You should seek emergency services and/or "911" services (including ambulance transportation) if you believe that a medical condition is an emergency medical condition in accordance with Community Health Plan's definition of emergency services.

Follow-up Care

Follow-up care will be provided by your Primary Care Provider. Do not go back to the emergency room for routine follow-up care. Contact your Primary Care Provider to make an appointment when you need follow-up health care services.

Emergency Care Out of the Plan's Service Area

The Plan is responsible for payment for genuine emergency services you may receive out of the Plan's Service Area. If an emergency occurs while you are out of the Service Area and you are unable to defer care until you get to a Plan hospital, you should go to the nearest hospital emergency room. Your Plan identification card will explain to the hospital staff how to notify the Community Health Plan about your emergency and how to receive payment.

Non-Qualifying Services

The Community Health Plan will only reimburse non-Plan hospitals or doctors outside of the Service Area for genuine emergency services. If you see a doctor or go to a hospital for a medical condition or situation which is not an emergency or which could reasonably be deferred until you returned to the Plan's Service Area, you may have to pay the entire bill.

What To Do When You Require Urgently Needed Services

Many Community Health Plan clinics and providers have urgent care services in the evenings and on weekends. During regular clinic/doctor office hours, if you need urgent care, call your Primary Care Provider. You will be given information as to what to do. If you need urgent care after clinic/doctor office hours, on weekends or holidays, or when you are out of the Plan's service area, call the Plan's After-Hours Medical Advice Service. You will speak with a Plan doctor or nurse, and she/he will tell you how and where to access care. The after-hours telephone number is 1 (800) 832-MEDI (1-800-832-6334).

If you speak a language other than English, we have interpreters available 24 hours who speak your language. Our interpreters will assist you whenever you call the Plan, including when you call the After-Hours Medical Advice Service or visit any of the Plan providers for care. (Currently, the Plan's interpreter services are supplemented by the AT&T Language Line interpreters.)

How to Get Non-Emergency Transportation

If you need non-emergency medical transportation, contact your Primary Care Provider or Case Manager. You can also contact Community Health Plan's Medical Administration Department at 1 (626) 299-5539.

YOUR RIGHTS AND RESPONSIBILITIES

Member Bill of Rights

Your rights as a Subscriber are listed below. Also included are your responsibilities in assisting the Plan in meeting your health care needs.

You have the right to:	**You are responsible for:**
1. Have a confidential relationship with your Primary Care Provider, specialist, and other health care professionals involved in your care.	1. Participating in your health care and the health care of eligible family Subscribers. This means taking care of problems before they become serious. You should always follow your providers' instructions, take all your medications, and participate in health programs that keep you well.
2. Have access to your medical records and have them kept confidential. This means that your medical records will remain confidential and will not be released without your permission.	2. A copy of the Plan's policy on confidentiality of medical information will be made available to you upon request by calling the Plan's Member Services Department at 1 (800) 475-5550. Using the emergency room for real emergencies only. Your Primary Care Provider will provide most of the medical care you need.
3. Have an appointment with your providers within a reasonable time and have your providers listen and work with you to take care of your health care needs.	3. Being courteous and cooperative to people who provide you or your family with health care services.
4. Dignified, courteous, and considerate care regardless of race, creed, sex, age, or cultural and/or ethnic background.	4. Making and keeping appointments for check-ups. You should always call when you need to cancel.
5. Be informed of all procedures, including appeals and grievances.	5. Participating in satisfaction surveys.
6. Receive information and to be spoken to in the language that you understand and are comfortable with. The Subscriber has the availability of interpreter services at no	6. Providing information on your language preference.

You have the right to:	You are responsible for:
charge and the right to file a grievance if cultural and linguistic needs are not met.	
7. Refuse medical treatment.	7. Informing your doctor that you would like to refuse medical treatment.
8. Receive preventive health care services.	8. Complying with your doctor's recommendations about staying healthy.
9. Know and understand your medical problem and treatment plan.	9. Asking questions and explanations if you don't understand or need more information.
10. Have a response to a request for service, including routine specialty referral authorization, within three (3) working days. You can also have an urgent referral authorization request the same day, and an emergency referral authorization request immediately upon request.	10. Following Plan guidelines and informing your doctor about care you receive.
11. A second medical opinion.	11. Following Plan guidelines.
12. Know when your Primary Care Provider is no longer contracted with Community Health Plan.	12. Calling the Plan's Member Services Department when you have a question.
13. Protect the information in your medical records.	13. Keeping your medical record information and identification card(s) in a safe place.
14. Have your medical Grievance referred to the Plan's Medical Director.	14. Following Plan guidelines.
15. Request our written policies and procedures about how we decide to approve, change, delay, or deny a service that your provider has requested.	15. You may request this information by calling or writing to our Member Services Department at 1 (800) 475-5550.

JOINING COMMUNITY HEALTH PLAN HEALTHY FAMILIES

When Does Coverage Begin

Enrollment in the Community Health Plan becomes effective at 12:01 a.m. Pacific Standard Time on the date specified by the Healthy Families Program. The Program will notify you in writing of the effective date of Plan enrollment and health care coverage for all persons determined to be eligible for the Program.

The Program will notify you in writing of the effective date of Plan enrollment and health care coverage for all persons determined to be eligible for the Program.

Identification Cards

Included in your new Subscriber packet are identification cards for all eligible family members who are enrolled in the Plan through the Healthy Families Program. Please check the cards for accuracy, and if there are any errors, contact the Plan's Member Services Department 1 (800) 475-5550. You can also submit an application to the Healthy Families Program to apply for additional persons.

Take your identification card with you whenever you have a doctor's appointment, pick up a prescription, or need medical care. Always have the card available when making appointments.

Having the card with you is important, in case of an emergency. The front of the card identifies you as a Community Health Plan Subscriber, and the back of the card tells a non-Plan hospital or clinic how to notify the Plan about your emergency and how to get paid by the Plan. If you are admitted to a hospital other than a Plan hospital, the Plan must be notified within 48 hours of admission.

If you do not remember the primary care clinic/provider you chose when you enrolled in the Plan, please contact the Plan's Member Services Department at 1 (800) 475-5550. Your primary care clinic/provider is where you will receive your regular medical care, and it is important for you to keep the clinic/doctor office address, telephone number and clinic hours handy.

If you lose your Plan identification card, call the Plan's Member Services Department at 1 (800) 475-5550 right away.

Changes in Family Information

If you move, you must notify the Healthy Families Program, in writing, within 30 days of any change in your billing address or any change of residence of a person participating in the Program. An address change or new telephone number is to be reported to the Plan also. You can contact a Plan Representative at your primary care clinic/doctor office (listed in the Community Health Plan Provider Directory) or call the Plan's Member Services Department at 1 (800) 475-5550.

PAYMENT RESPONSIBILITIES

Copayments

Healthy Families Program Copayments will apply for certain services provided to Subscribers (except as provided under Federal law to Subscribers who are American Indian descent receiving services at an Indian Health Service Facility) or Alaska Natives. Preventive health care services do not require copayments. Whenever a family's Copayments exceed $25 in one month, arrangements can be made for extended payment plans through your provider. Community Health Plan Covered Services that have Copayments are listed in the "Health Plan Benefits Summary" section of this guidebook.

Annual Copayment Maximum

Healthy Families Program's total annual, family maximum Copayment is $250. This maximum is renewed on July 1st of each year. Keep a record of the amount of Copayments paid and keep the receipts together in a safe place. When the total Copayments paid reaches $250, you can stop making Copayments. You should photocopy the receipts and send the original receipts to:

Community Health Plan
1000 South Fremont Avenue
Building A-9 East, 2nd Floor, Unit #4
Alhambra, CA 91803-1323
Attention: Member Services Department

Or, you can bring the receipts to your Primary Care Provider. A Plan Representative will make copies for you and make sure that you receive your proof of reaching the $250 annual, family Copayment maximum. The Plan will provide you with a "Copayment Certification" letter, which will verify that you are no longer required to make Copayments for the remainder of the Benefit Year. Keep the "Copayment Certification" letter with you whenever you obtain care and show it whenever you are asked about paying a Copayment. If you need assistance with a copayment problem, contact your Primary Care Provider or the Plan's Member Service Department at 1 (800) 475-5550.

Subscriber Liabilities

1. By statute and contract with providers, a Subscriber will not be held liable for payment of Plan-referred services to any provider contracted with the Plan in the event that the Community Health Plan fails to pay the provider.

2. Healthy Families Program Applicants are responsible for submitting Family Contribution payments to the Program of the specified due date.

3. Copayments for Covered Services provided to Plan Subscribers are to be paid at the time services are rendered or within 30 days after the Applicant receives notice from the Plan.

4. The Community Health Plan will reimburse non-Plan providers for authorized services and genuine emergency care only. If non-authorized health care services are obtained on a non-emergent basis from a provider not affiliated with your Primary Care Provider, you may be responsible for payment of the entire bill.

HEALTH PLAN BENEFITS

Hospital Facilities

Inpatient Services: General hospital services, in a room of two or more, with customary furnishings and equipment, meals (including special diets as medically necessary), and general nursing care. All medically necessary ancillary services such as use of operating room and related facilities; intensive care unit and services; drugs, medications, and biologicals; anesthesia and oxygen; diagnostic laboratory and x-ray services; special duty nursing as medically necessary; physical, occupational, and speech therapy; respiratory therapy; administration of blood and blood products; other diagnostic, therapeutic and rehabilitative services as appropriate; and coordinated discharge planning, including the planning of continuing care as may be necessary.

Inpatient hospital services. This includes coverage for general anesthesia and associated facility charges, in connection with dental procedures when hospitalization is necessary because of an underlying medical condition or clinical status or because of the severity of the dental procedure. This benefit is only available to subscribers under 7 years of age; to developmentally disabled, regardless of age; and subscribers whose health is compromised and for whom general anesthesia is medically necessary, regardless of age. The Plan will coordinate such services with the Subscriber's participating dental plan. Services of the dentist or oral surgeon are excluded for dental procedures under the Program's health benefits but may be covered under the Program's dental benefits.

Exclusions: Personal or comfort items or a private room in a hospital are excluded, unless medically necessary.

Outpatient Services: Diagnostic, therapeutic and surgical services performed at a hospital or outpatient facility. This includes physical, occupation, and speech therapy as appropriate; and those hospital services which can reasonably be provided on an ambulatory basis. Related services and supplies in connection with these services including operating room, treatment room, ancillary services, and medications, which are supplied by the hospital or facility for use during the Subscriber's stay at the facility.

General anesthesia and associated facility charges, and outpatient services in connection with dental procedures when the use of a hospital or surgery center is necessary because of an underlying medical condition or clinical status or because of the severity of the dental procedure. This benefit is only available to subscribers under 7 years of age; the developmentally disabled, regardless of age; and subscribers whose health is compromised and for whom general anesthesia is medically necessary, regardless of age. The Plan will coordinate such services with the Subscriber's participating dental plan. Services of the dentist or oral surgeon are excluded for dental procedures.

Professional Services

Medically necessary professional services and consultations by a physician or other licensed health care provider acting within the scope of her or his license. Surgery, assistant surgery and

anesthesia (inpatient or outpatient); inpatient hospital and skilled nursing facility visits; professional office visits including visits for allergy tests and treatments, radiation therapy, chemotherapy, and dialysis treatment; and home visits when medically necessary. In addition, professional services include:

Eye Examinations
For the Subscriber including eye refractions to determine the need for corrective lenses, and dilated retinal eye examinations. For subscriber parents, eye refraction is optional for plan.

Hearing Test, Hearing Aids and Services
Audiological evaluation to measure the extent of hearing loss and a hearing aid evaluation to determine the most appropriate make and model of hearing aid.

Hearing aid: Monaural or binaural hearing aids including ear mold(s), the hearing aid instrument, the initial battery, cords and other ancillary equipment. Visits for fitting, counseling, adjustments, repairs, etc., at no charge for a one-year period following the provision of a covered hearing aid.

Limitation: For Subscriber parents, this is limited to a maximum of $1000 per member every thirty-six months for the hearing instrument and ancillary equipment.

Exclusions: The purchase of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase and charges for a hearing aid which exceeds specifications prescribed for correction of a hearing loss. Replacement parts for hearing aids, repair of hearing aid after the covered one-year warranty period, replacement of a hearing aid more than once in any period of thirty-six months, and surgically implanted hearing devices.

Well Baby Care
Well baby care during the first 2 years of life, including newborn hospital visits, health examinations and other office visits.

Immunizations for Subscriber children:
Immunizations consistent with the most current version of the Recommended Childhood Immunization Schedule/United States, adopted by the Advisory Committee on Immunization Practices (ACIP). Immunizations required for travel as recommended by the ACIP, and other age appropriate immunizations as recommended by the ACIP.

Periodic Health Examinations
Periodic health examinations, including all routine diagnostic testing and laboratory services appropriate for such examinations consistent with the most current Recommendations for Preventative Pediatric Health Care, as adopted by the American Academy of Pediatrics; and the most current version of the Recommended Childhood Immunization Schedule/United States, adopted by the Advisory Committee on Immunization Practices (ACIP).

Limitations: The frequency of such examinations shall not be increased for reasons which are unrelated to the medical needs of the Subscriber including: a Subscriber's desire for physical

examinations; or reports or related services for the purpose of obtaining or maintaining employment, licenses, insurance, or a school sports clearance.

Preventative Services
Preventative services will be provided for the detection of a symptomatic diseases. These services include periodic health examinations, voluntary family planning services, prenatal care, vision and hearing testing, immunizations, venereal disease testing, cytology examinations (on a reasonable basis), and effective health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the Plan and health care organizations affiliated with the Plan.

Prescription Drugs
Medically necessary drugs when prescribed by a licensed practitioner acting within the scope of his or her licensure. This includes injectable medication and needles and syringes necessary for the administration of the covered injectable medication. Also includes insulin, glucagons, syringes and needles and pen delivery systems for the administration of insulin, blood glucose testing strips, ketone urine testing strips, lancets and lancet puncture devices in medically appropriate quantities for the monitoring and treatment of insulin dependent, non-insulin dependent and gestational diabetes Prenatal vitamins and fluoride supplements included with vitamins or independent of vitamins which require a prescription

Medically necessary drugs administered while a Subscriber is a patient or resident in a rest home, nursing home, convalescent hospital or similar facility when prescribed by a plan physician in connection with a covered service and obtained through a plan designated pharmacy.

The Plan may specify that generic equivalent prescription drugs must be dispensed if available, provided that no medical contraindications exist. The use of formulary, maximum allowable cost (MAC) method, and mail order programs by the Plan are encouraged.

The Plan shall provide coverage for one cycle or course of treatment of tobacco cessation drugs per benefit year. The Plan must also require the member to attend tobacco use cessation classes or programs in conjunction with tobacco cessation drugs.

Contraceptive Drugs and Devices: Community Health Plan provides coverage for all Federal Food and Drug Administration approved oral and injectable contraceptive drugs and prescription contraceptive devices are covered including internally implanted time release contraceptives such as Norplant.

Exclusions: Experimental or investigational drugs, unless accepted for use by the standards of the medical community; drugs or medications for cosmetic purposes; patent or over-the-counter medicines, including non-prescription contraceptive jellies, ointments, foams, condoms, etc.; medicines not requiring a written prescription order (except insulin and smoking cessation drugs as previously described); and dietary supplements (except for formulas or special food products to treat phenylketonuria or PKU), and appetite suppressants or any other diet drugs or medications.

Diagnostic X-ray and Laboratory Services
Diagnostic laboratory services, diagnostic and therapeutic radiological services necessary to appropriately evaluate, diagnose, treat, and follow-up on the care of Subscribers, and other diagnostic services, which shall include, but not be limited to, electrocardiography, electroencephalography, and mammography for screening or diagnostic purposes.

Laboratory tests appropriate for the management of diabetes, including at a minimum: cholesterol, triglycerides, microalbuminuria, HDL/LDL and Hemoglobin A-1C (Glycohemoglobin).

Durable Medical Equipment
Medical equipment appropriate for use in the home which: 1) is intended for repeated use; 2) is generally not useful to a person in the absence of illness or injury; and 3) primarily serves a medical purpose. The Plan may determine whether to rent or purchase standard equipment. Repair or replacement is covered unless necessitated by misuse or loss. Oxygen and oxygen equipment; blood glucose monitors and blood glucose monitors for the visually impaired as medically appropriate for insulin dependent, non-insulin dependent, and gestational diabetes; insulin pumps and all related supplies; visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin, and apnea monitors podiatric devices to prevent or treat diabetes complications; pulmoaides and related supplies; nebulizer machines, tubing and related supplies, and spacer devices for metered dose inhalers; ostomy bags and urinary catheters and supplies.

Exclusions: Coverage for comfort or convenience items; disposable supplies except ostomy bags and urinary catheters and supplies consistent with Medicare coverage guidelines; exercise and hygiene equipment; experimental or research equipment; devices not medical in nature such as sauna baths and elevators, or modifications to the home or automobile; deluxe equipment; or more than one piece of equipment that serve the same function.

Orthotics and Prosthetics
Orthotics and prosthetics including medically necessary replacement prosthetic devices as prescribed by a licensed practitioner acting within the scope of his or her licensure, and medically necessary replacement orthotic devices when prescribed by a licensed practitioner acting within the scope of his or her license. Coverage for the initial and subsequent prosthetic devices and installation accessories to restore a method of speaking incident to a laryngectomy, and therapeutic footwear for diabetics.

Also includes prosthetic devices to restore and achieve symmetry incident to mastectomy.

Exclusions: Corrective shoes and arch supports, except for therapeutic footwear and inserts for individuals with diabetes; non-rigid devices such as elastic knee supports, corsets, elastic stockings, and garter belts; dental appliances; electronic voice producing machines; or more than one device for the same part of the body. Also does not include eyeglasses (except for eyeglasses or contact lenses necessary after cataract surgery).

Cataract Spectacles and Lenses
Cataract spectacles, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery are covered. Also one pair of conventional eyeglasses or conventional contact lenses is covered if necessary after cataract surgery with insertion of an intraocular lens.

Maternity Care
Medically necessary professional and hospital services relating to maternity care including: Pre-natal and post-natal care and complications of pregnancy; newborn examinations, phenylketonuria (PKU) testing and treatment, and nursery care while the mother is hospitalized. Includes providing coverage for participation in the statewide prenatal testing program administered by the State Department of Health Services known as the Expanded Alpha Feto Protein Program. The timing of discharge of mother and newborn will be made by the treating physician in consultation with the mother. Inpatient stay for mother and newborn will be covered for 48 hours in normal vaginal birth, and 96 hours in the case of cesarean section birth. If inpatient stay is less than as specified above, a post-discharge visit will be provided to the mother and her newborn within 48 hours of discharge. The post-discharge visit will be either an in-home, provider office, or Plan facility visit.

Family Planning
Voluntary family planning services including counseling and surgical procedures for sterilization as permitted by state and federal law, diaphragms, and coverage for other federal Food and Drug Administration approved devices and contraceptive drugs pursuant to the prescription drug benefit.

"Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call Community Health Plan 1 (800) 475-5550 to ensure that you can obtain the health care services that you need."

Medical Transportation Services
Emergency ambulance transportation in connection with emergency services to the first hospital, which actually accepts the Subscriber for emergency care. Includes ambulance and ambulance transport cervices provided through the "911" emergency response system.

Non-emergency transportation for the transfer of a Subscriber from a hospital to another hospital or facility or facility to home when:

(A) Medically necessary, and

(B) Requested by a Plan provider, and

(C) Authorized in advance by participating health Plan.

Exclusions: Coverage for transportation by airplane, passenger car, taxi or other form of public conveyance.

Emergency Health Care Services
Twenty-four hour emergency care for alleviation of sudden, serious, and unexpected illness, injury or severe pain or for immediate diagnosis and treatment of any condition in which the subscriber is in danger of loss of life, serious illness or disability, or which would so appear to a prudent person. This must be provided both in and out of the Plan's service area and in and out of the Plan's network

This must be provided both in and out of the health plan service area and in and out of the health plan's participating facilities.

Mental Health

(A) "Inpatient"

Mental health care during a certified confinement in a participating hospital when ordered and performed by a participating mental health professional for the treatment of a mental health condition. For the Subscriber children who is determined by their county mental health department to meet the criteria for Serious Emotional Disturbances (SED) of a child. The Plan may limit services to 30 days per benefit year, Community Health Plan is responsible for identifying Subscriber children who may be SED and shall refer these individuals for determination. For Subscriber children who are determined as SED by their county mental health department, the Plan shall provide up to 30 days of inpatient care and shall then refer these individuals to their county mental health department for continued treatment of the condition.

Except as limited pursuant to the previous paragraph for subscribers who are determined as SED by their county mental health department, the Plan must provide services with no visit limits for severe mental illnesses including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.

The Plan may limit coverage to 30 days per benefit year for illnesses that meet neither the criteria for severe mental illnesses, nor the criteria for SED of a child.

Community Health Plan may, with the agreement of the Subscriber or Applicant or other responsible adult if appropriate, may substitute for each day of inpatient hospitalization any of the following: two (2) days of residential treatment, three (3) days of day care treatment, or four (4) outpatient visits.

(B) Outpatient

Mental health care when ordered and performed by The Plan includes the treatment of children who have experienced family dysfunction or trauma, including child abuse and

neglect, domestic violence, substance abuse in the family, or divorce and bereavement. Family members may be involved in the treatment to the extent the Plan determines it is appropriate for the health and recovery of the child.

The Plan must provide services with no visit limits for severe mental illnesses, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa and bulimia nervosa. The Plan shall be responsible for identifying Subscriber children who may be SED and shall refer these individuals to their county mental health department for determination. Notwithstanding the first sentence of this paragraph, the Plan shall refer Subscriber children who are determined by their county mental health department as SED to their county mental health department for treatment of the condition.

The Plan will provide up to 20 visits per benefit year. The Plan will limit coverage to 20 days per benefit year for illnesses that meet neither the criteria for severe mental illnesses, nor the criteria for SED of a child.

The Plan may elect to provide additional visits. The Plan will provide group therapy at a reduced copayment.

Exclusions: Mental disorders that do not respond to generally accepted methods of treatment.

Alcohol and Drug Abuse

(A) Inpatient: Hospitalization for alcoholism or drug abuse as medically appropriate to remove toxic substances from the system.

(B) Outpatient: Crisis intervention and treatment of alcoholism or drug abuse on an outpatient basis as medically appropriate. Community Health Plan will offer at least 20 visits per benefit year and may elect to provide additional visits.

Home Health Services

Health services provided at the home by health care personnel. Includes visits by Registered Nurses, Licensed Vocational Nurses, and home health aides; physical, occupational and speech therapy; and respiratory therapy when prescribed by a licensed practitioner acting within the scope of his or his licensure.

Limitations: Home health services are limited to those services that are prescribed or directed by the attending physician or other appropriate authority designated by the Plan. If a basic health service can be provided in more than one medically appropriate setting, it is within the discretion of the attending physician or other appropriate authority designated by the Plan to choose the setting for providing the care. The Plan will exercise prudent medical case management to ensure that appropriate care is rendered in the appropriate setting. Medical case management may include consideration of whether a particular service or setting is cost-effective when there is a choice among several medically appropriate alternative services or settings.

Exclusion: Custodial care.

Physical, Occupational, and Speech Therapy
Therapy may be provided in a medical office or other appropriate outpatient setting, hospital, skilled nursing facility or home. The Plan requires periodic evaluations as long as therapy, which is medically necessary, is provided.

Skilled Nursing Care
Services prescribed by a Plan physician or nurse practitioner and provided in a licensed skilled nursing facility when medically necessary. Skilled nursing on a 24-hour per day basis; bed and board; x-ray and laboratory procedures; respiratory therapy; physical, occupational and speech therapy; medical social services; prescribed drugs and medications; medical supplies; and appliances and equipment ordinarily furnished by the skilled nursing facility. This benefit will be limited to a maximum of 100 days per benefit year.

Exclusions: Custodial care.

Health Education
Effective health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the Plan or health care organizations affiliated with the Plan.

Hospice
The hospice benefit include nursing care, medical social services, home health aide services, physician services, drugs, medical supplies and appliances, counseling and bereavement services. The benefits also include physical therapy, occupational therapy, speech therapy, and short-term inpatient care for pain control and symptom management.

The hospice benefit may include, at the option of the health plan, homemaker services, services of volunteers, and short-term inpatient respite care.

Limitations: The hospice benefit is limited to those individuals who are diagnosed with a terminal illness with a life expectancy of twelve months or less and who elect hospice care for such illness instead of traditional services covered by the Plan.

Individuals who elect hospice care are not entitled to any other benefits under the Plan for the terminal illness while the hospice election is in effect. The hospice election may be revoked at any time.

Transplants
Coverage for medically necessary organ transplants and bone marrow transplants, which are not experimental or investigational in nature. Reasonable medical and hospital expenses of a donor or an individual identified as a prospective donor if these expenses are directly related to the transplant for a Subscriber.

Charges for testing of relatives for matching bone marrow transplants. Charges associated with the search and testing of unrelated bone marrow donors through a recognized Donor Registry and charges associated with the procurement of donor organs through a recognized Donor Transplant Bank, if the expenses are directly related to the anticipated transplant of a Subscriber.

Exclusions: Custodial care.

Blood and Blood Products
Processing, storage, and administration of blood and blood products in inpatient and outpatient settings. Includes the collection and storage of autologous blood when medically indicated.

Reconstructive Surgery and Care
Reconstructive surgery restore and achieve symmetry and surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to do either of the following:

Improve function

(B) Create a normal appearance to the extent possible

Includes reconstructive surgery to restore and achieve symmetry incident to mastectomy.

Exclusion: Cosmetic surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.

Mastectomy Surgery and Care
A mastectomy is a covered benefit, as medically determined by a Plan physician and/or surgeon. Treatment benefits include: mastectomy, mastectomy and lymph node dissection, prosthetic device, restoration and symmetry achievement and complications associated with these procedures. The hospital stay will be determined by the attending physician and surgeon.

Diabetes Outpatient Self-Management
Covered benefits provide for diabetes outpatient self-management training, education, and medical nutrition therapy necessary to enable Applicant or Subscriber to properly use diabetes management and treatment equipment, supplies, and medications. Diabetes outpatient self-management training, education, nutrition therapy are provided by appropriately licensed or registered health care professionals.

Breast Cancer
Community Health Plan provides coverage on breast cancer screening, diagnosis, and treatment of breast cancer, consistent with generally accepted medical practice and scientific evidence upon referral of your physician.

Cancer Screening
Community Health Plan provides coverage for all generally medically accepted cancer-screening tests.

Cervical Cancer Screening Test
If you are referred by your Primary Care Physician (PCP) or treating provider, you may get any other Cervical Cancer Screening test that is approved by the Food and Drug Administration (FDA), in addition to the usual annual Pap Smear Test.

Cancer Clinical Trials
If you have cancer, you may be able to be part of a cancer clinical trial that meets certain requirements, when referred by your Community Health Plan PCP or treating provider. The cancer clinical trial must be for a meaningful potential to benefit you and must be approved by one of the following:

- National Institute of Health (NIH)
- Food and Drug Administration (FDA)
- U.S. Department of Defense
- U.S. Veteran's Administration

If you are part of an approved cancer clinical trial, Community Health Plan will provide coverage for all routine patient care cost related to the cancer clinical trial.

If you have a life threatening or debilitating condition or were eligible, but denied coverage for a Cancer Clinical Trial, you have the right to request an Independent Medical Review (IMR) on the denial.

NOTE: You should carefully review the "Exclusions and Limitations" section of this guidebook for more information regarding excluded services not provided by the Healthy Families Program.

LINKAGES TO OTHER PROGRAMS

California Children's Services (CCS)

As part of the services provided through the Healthy Families Program (HFP), children needing specialized medical care may be eligible for the California Children's Services (CCS) Program.

CCS is a California medical program that treats Subscriber's children under the age of 21 with **certain physically handicapping conditions and who need specialized medical care**. This program is available to all Subscriber's children in California whose families meet certain medical, financial and residential eligibility requirements. Subscriber's children enrolled in the HFP are deemed to have met the financial eligibility requirements of the CCS Program. Services provided through the CCS Program are coordinated by the local county CCS office

If a Healthy Families Program (HFP) member's Primary Care Physician (PCP) suspects or identifies a possible CCS eligible condition, he/she **must refer** the member to the local county CCS Program. The CCS Program (local or the CCS Regional Office) will determine if the member's condition is eligible for CCS services.

If determined to be eligible for CCS services, a HFP member continues to stay enrolled in the HFP. He or she will be referred and **should receive** treatment for the CCS eligible condition **through the specialized network of CCS providers and/or CCS approved specialty centers**. These CCS providers and specialty centers are highly trained to treat CCS eligible conditions. Community Health Plan will continue to provide primary care and prevention services that are not related to the CCS eligible condition, as described in this document, and will also work with the CCS Program to coordinate care provided by both the CCS Program and the plan.

Although all children enrolled in the HFP are determined to be financially eligible for the CCS Program, the CCS office must verify residential status for each child in the CCS Program. If your child is referred to the CCS Program, you will be asked to complete a short application to verify residential status and ensure coordination of your child's care after the referral has been made.

Additional information about the CCS Program can be obtained by calling your child's provider or the Plan's Medical Administration Department at 1 (626) 299-5539.

County Mental Health Benefits for Serious Emotionally Disturbed (SED) Children

As part of the services provided through the Healthy Families Program (HFP), children needing specialized mental health services may be referred to the County Mental Health Program.

If a member is suspected of having a Seriously Emotionally Disturbed (SED) eligible condition, he or she will be referred to his or her county's mental health department for assessment and specialized treatment.

When a child is determined to be SED, care for the SED condition will be provided by the county mental health program. The child will remain enrolled in Community Health Plan and will receive mental health services unrelated to the SED condition. Services provided by the county for the SED condition may include individual or family therapy, or counseling assistance with medication related to mental health condition and day programs.

Additional information about services for children with SED can be obtained by contacting your county's mental health department. The phone number of your county mental health department can be found in the "governmental listing" section of the phone book under the heading "County Government Offices."

EXCLUSIONS AND LIMITATIONS

The Plan does not provide coverage for all types of health care. There are some services which are excluded and are not part of the benefit package. The following are excluded services not provided by the:

- Personal or comfort items or a private room in a hospital, unless medically necessary.
- Medical, surgical (including implants), or other health care procedures, services, products, drugs, or devices which are either: 1) experimental or investigational or which are not recognized in accord with generally accepted medical standards as being safe and effective for use in the treatment in question, or 2) outmoded or not efficacious.
- Drugs or medications for cosmetic purposes; patent or over-the-counter medicines, including non-prescription contraceptive jellies, ointments, foams, condoms, etc.; medicines not requiring a written prescription order (except insulin); and dietary supplements, appetite suppressants or any other diet drugs or medications.
- Comfort or convenience items.
- Disposable supplies (except ostomy bags, urinary catheters, and supplies consistent with Medicare coverage guidelines).
- Exercise and hygiene equipment; experimental or research equipment; devices not medical in nature such as sauna baths and elevators, or medications to the home or automobile; deluxe equipment; or more than one piece of equipment that serves the same function.
- Corrective shoes and arch supports (except for therapeutic footwear for diabetes); non-rigid devices such as elastic knee supports, corsets, elastic stockings, and garter belts.
- Dental appliances; electronic voice producing machines; or more than one device for the same part of the body.
- Transportation by airplane, passenger car, taxi or other form of public conveyance.
- Acupuncture and chiropractic services.
- Biofeedback services.
- Purchase of replacement hearing aid batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase; charges for a hearing aid which exceed specifications prescribed for correction of a hearing loss; replacement parts for hearing aids; repair of a hearing aid after the covered one (1) year warranty period; replacement of a hearing aid more than once in any period of 36 months; and surgically implanted hearing devices.
- Services, supplies, items, procedures or equipment, which are not medically necessary as determined by the Plan, unless specified by contract.

EXCLUSIONS AND LIMITATION (continued)

- Any services received prior to the Subscriber's effective date of coverage or after coverage ends.
- Emergency facility services for non-emergency conditions.
- Eyeglasses, except for those eyeglasses or contact lenses necessary after cataract surgery.
- Treatment for infertility. Diagnosis of infertility for Subscribers is not covered unless provided in conjunction with covered gynecological services. Treatment of medical conditions of the reproductive system are not excluded.
- Long-term care benefits, including long-term skilled nursing care in a licensed facility and respite care.
- Treatment for any bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which benefits are provided or payable under any Worker's Compensation benefit plan. The Plan will provide the services at the time of need, and the Subscriber or applicant shall cooperate to assure that the Plan is reimbursed for such benefits.
- Cosmetic surgery that is solely performed to alter or reshape normal structures of the body in order to improve appearance.
- Services which are eligible for reimbursement by insurance or covered under any other insurance or health care service plan. The Plan will provide the services at the time of need, and the Subscriber or Applicant shall cooperate to assure that the Plan is reimbursed for such benefits.
- Covered benefits do include inpatient hospital services in connection with dental procedures when hospitalization is required because of an underlying medical condition and clinical status or because of the severity of the dental procedure. The Plan will coordinate such services with the Subscriber's participating dental plan. Services of the dentist or oral surgeon are excluded for dental procedures under the Program's health benefits but may be covered under the Program's dental benefits.
- Covered benefits do include outpatient services in connection with dental procedures when the use of a hospital or outpatient facility is required because of an underlying medical condition and clinical status or because of the severity of the dental procedure. The Plan will coordinate such services with the Subscriber's participating dental plan. Services of the dentist or oral surgeon are excluded for dental procedures under the Program's health benefits but may be covered under the Program's dental benefits.
- Increased frequency of periodic health examinations for reasons which are unrelated to the medical needs of the Subscriber including: a Subscriber's desire for physical examination; or reports or related services for the purpose of obtaining or maintaining employment, licenses, insurance, or a school sports clearance.

GENERAL INFORMATION

Grievances and Appeals

The Community Health Plan is interested in resolving any problems you may have with the services you receive. As a Community Health Plan Subscriber, you have the following rights under the Plan's grievance procedures:

1. You have the right to submit a formal grievance. You can contact your provider or the Plan's Member Services Department. A Plan Representative will assist you in completing your written grievance. You will receive a letter, within five (5) business days, acknowledging receipt of your grievance. The Community Health Plan staff will investigate and take steps to resolve the problem(s) to your satisfaction. You will receive a written response explaining the actions taken, within 30 days of the date of receipt of your grievance. Your grievance will be resolved within 30 days.

2. If you are not satisfied with the resolution of the grievance, a written appeal may be submitted within 30 days of the Plan's decision to:

   Community Health Plan
   1000 South Fremont Avenue
   Building A-9 East, 2nd Floor, Unit #4
   Alhambra, CA 91803-1323
   Attention: Grievance Coordinator
   1 (800) 475-5550

3. If you believe you need legal representation, contact your attorney or the Legal Aid Foundation at 1 (213) 487-3320 for advice.

A Plan Representative is available to assist you and provide information. If you have any questions regarding the grievance procedures, please call a Plan Representative at your primary care clinic/doctor office, or you may contact the Plan's Member Services Department at 1 (800) 475-5550.

Community Health Plan will conduct an expedited review of a grievance involving an imminent and serious threat to your health, including but not limited to, to severe pain, the potential loss of life, limb, or major bodily function. The Health Plan does not require a member request to provide an expedited review in specified cases. You may also appeal directly to the Plan Administrator. You will be advised of the findings within a period not to exceed 72 hours after the Plan's receipt of the expedited review request. A grievance and/or appeal can be submitted by the Applicant, Subscriber or a selected representative.

Independent Medical Review of Grievance Involving a Disputed Health Care Service (Model Language For EOC Disclosures)

You may request an independent medical review ("IMR") of disputed health care services from the Department of Managed Health Care ("DMHC") if you believe that health care services have been improperly denied, modified, or delayed by the Plan or one of its contracting providers. A "disputed health care service" is any health care service eligible for coverage and payment under your subscriber contract that has been denied, modified, or delayed by the Plan or one of its contracting providers, in whole or in part because the service is not medically necessary.

The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. The Plan must provide you with an IMR application form with any grievance disposition letter that denies, modifies, or delays health care services. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against the plan regarding the disputed health care services.

Eligibility: Your application for IMR will be reviewed by the DMHC to confirm that:

(1) (A) Your provider has recommended a health care service as medically necessary, or (B) You have received urgent care or emergency services that a provider determined was medically necessary, or (C) You have been seen by an in-plan provider for the diagnosis or treatment of the medical condition for which you seek independent review;

(2) The disputed heath care service has been denied, modified, or delayed by the Plan or one of its contracting providers, based in whole or in part on a decision that the health care service is not medically necessary; and

(3) You have filed a grievance with the plan or its contracting provider and the disputed decision is upheld or the grievance remains unresolved after 30 days. If your grievance requires expedited review you may bring it immediately to the Department's attention. The DMHC may waive the requirement that you follow the Plan's grievance process in extraordinary and compelling cases.

If your case is eligible for IMR, the dispute will be submitted to a medical specialist who will make an independent determination of whether or not the care is medically necessary. You will receive a copy of the assessment made in your case. If the IMR determines the service is medically necessary, the plan will provide the health care service.

For non-urgent cases, the IMR organization designated by the DMHC must provide it determination within 30 days of receipt of your application and supporting documents. For urgent cases involving imminent and serious threat to your health, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of your health, the IMR organization must provide its determination within 3 business days.

For more information regarding the IMR process, or to request an application form, please call the Community Health Plan's Member Services Department at 1 (800) 475-5550.

"The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. DMHC has a toll-free number **1-888-HMO-2219 (1888-466-2219)** to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers **(1-800-735-2929 [TTY] or 1-888-877-5378 [TTY])** to contact DMHC. DMHC's Internet website (**http://www.hmohelp.ca.gov**) has complaint forms and instructions online. If you have a grievance against your health plan, you should first call **Community Health Plan** at **1 (800) 475-5550** and use the plan's grievance process before contacting DMHC. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan, or a grievance that has remained unresolved for more than 30 days, you may call DMHC for assistance. The plan's grievance process and DMHC's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law."

Arbitration

In the event the parties are unable to resolve a dispute informally within thirty (30) calendar days of the date such written notice was delivered, either party may submit the matter to arbitration, upon written notice thereof to the other party. The arbitration shall be conducted by a single neutral arbitrator selected in accordance with the Commercial Arbitration Rules of the American Arbitration Association. The arbitrator shall conduct the arbitration in accordance with such rules. The above notwithstanding, the California rules of discovery shall apply to any such arbitration. The judgment rendered by the arbitrator shall be final and binding on the parties. For all disputes subject to binding arbitration, all parties give up the right to a jury or court trial. Reasonable legal fees and costs of the prevailing party, as well as the costs of arbitration shall be borne by the non-prevailing party, unless the arbitrator expressly determines to the contrary; provided, however, that in no event shall the prevailing party be responsible for more than its legal fees and costs, or for more than one-half of the costs of arbitration. This binding arbitration provision does not apply to claims, disputes, or controversies relating solely to alleged medical malpractice.

Coordination of Benefits

Community Health Plan will ensure that you receive the best health care and that there is no interruption in the care you receive when you become a Subscriber. The Plan will coordinate covered benefits with other health plans or insurers so that no more than one hundred percent (100%) of covered medical expenses are provided through the Plan and that Plan coverage is secondary to all other coverage.

Non-Duplication of Benefits with Worker's Compensation

You must notify the Plan right away, in writing, if you or another Plan Subscriber in your household are injured and become covered under any Worker's Compensation or other insurance

where another party is responsible for all or part of the cost of health care for you or other Plan Subscribers in your household.

The Community Health Plan will provide medical care if you are injured through the fault of someone else such as in an accident or on the job. Services provided to you for illness, injury or other medical conditions caused by a third party and which are covered by any other insurance or governmental program will be charged to you. The amount collected from you by the Community Health Plan will not exceed the amount you collect from the individual, governmental program, or insurance company. You must notify Community Health Plan if you think you will get money under any of these conditions. If you need information regarding non-duplication of benefits, contact the Plan's Member Services Department at 1 (800) 475-5550.

How Providers are Compensated

Community Health Plan providers who provide health care services to Subscribers are reimbursed from fees paid by the Healthy Families Program. Plan providers do not receive financial bonuses or incentives to deny, reduce, limit, or delay to Subscribers medically necessary and appropriate services which are covered by the Plan. If you would like additional information regarding provider compensation, contact your provider, her/his Medical Group, or the Plan's Member Services Department at 1 (800) 475-5550.

Limitation of Services

The Community Health Plan is responsible for providing services as summarized in this Combined Evidence of Coverage and Disclosure and as presented in detail in the Plan Contract. However, in the event of a major disaster, the Plan is not responsible for the delay or failure to render services. Plan physicians and other Plan providers will make a good faith effort to provider or to arrange for the provision of all Covered Services, in such event.

In the event you refuse to follow a Plan provider's recommendation for treatment of a specific condition and when the Plan provider believes that no acceptable alternative treatment exists, the Plan has no further liability for your condition, except as this may conflict with a properly executed advance directive. In accordance with State and Federal laws and regulations, if a Plan provider feels that she/he cannot comply with an advance directive, another Plan provider will be assigned to your case so that the advance directive may be fulfilled.

Advance Directives

An advance directive is a way for you to decide in advance what is to be done if you cannot make your wishes known to the doctor during an injury or serious illness. You can name someone to make medical decisions if you cannot make the decisions yourself, and you can write about whatever condition concerns you. Having an advance directive on file provides important information to your family members and providers about questions like:

- Do you want doctors to try everything they think might help? Even if you weren't able to go back to your home? Even if you might never become conscious again?
- Would you want to be fed through tubes if you were terminally ill?

People feel differently about these kinds of choices. By filling out an advance directive, you can let your family, friends, and providers know how you feel. In California, there are three kinds of advance directives:

- A Durable Power of Attorney for Health Care,
- A Natural Death Act Declaration, and
- A Living Will.

A Durable Power of Attorney for Health Care names someone to instruct your providers to carry out your wishes. A Natural Death Act Declaration or a Living Will can indicate exactly what your wishes are without naming someone to make decisions. If you have additional questions on advance directives and your rights under California Law, please write or call the Plan's Member Services Department at 1 (800) 475-5550.

Notifying You of Changes In the Plan

Community Health Plan will ensure that you are notified of changes in services provided or in the locations at which you may obtain services. You will receive a written notification of these changes 30 days before they occur. Or, in unforeseen circumstances, the notice will be 14 days before the changes occur.

Termination of Benefits

If any of the following occurs, Healthy Families coverage will end. Your child will be disenrolled if:

- Healthy Families Program finds that the child does not qualify during the Annual Eligibility Review; **or**
- You do not provide the information needed for your child's Annual Eligibility Review; **or**
- Your child reaches 19 years of age; **or**
- You do not pay your child's monthly premium for 60 days after the due date; **or**
- You write to Healthy Families asking to end enrollment; **or**
- Healthy Families finds that you made false declarations about your child's eligibility; **or**
- You do not provide documentation requested, birth certificates or INS documents when due.

You will receive a written termination notice before your child's health, dental and vision coverage ends and the child is disenrolled from the program.

The notice gives the reason and effective date of disenrollment. If you disagree with the decision, you may contact the Healthy Families Program at their toll free 1-800-880-5305.

Advisory Committee

You are encouraged to become involved in the Community Health Plan Advisory Committee. Committee members work with Plan administrators and other Plan staff to ensure the smooth operation of the Plan and to assure that Subscribers receive the best possible care. The committee meets periodically during the year at various locations throughout Los Angeles County. For more information about participating on this committee, call the Plan's Member Services Department at 1 (800) 475-5550.

Americans with Disabilities Act (ADA)

Physical Access

Community Health Plan has made every effort to ensure that our offices and the offices and facilities of Plan providers are accessible to the disabled. If you are not able to locate an accessible provider, please call our toll-free Member Services Department at 1 (800) 475-5550 and a Member Services Representative will help you find an alternate provider.

Access for the Hearing Impaired

The hearing impaired may contact a Member Services Representative through our TDD Service at 1 (626) 299-7265 & 7266.

Access for the Vision Impaired

This Combined Evidence of Coverage and Disclosure and other important plan materials will be made available in alternate formats for the vision impaired. Large print, enlarged computer disk formats, and an audiotape of this booklet are available. For alternate formats, or for direct help in reading the Combined Evidence of Coverage and Disclosure and other materials, please call a Member Services Representative at 1 (800) 475-5550.

Disability Access Grievances

If you believe the Plan or its providers have failed to respond to you disability access needs, you may file a Grievance with the Plan. If your disability access Grievance remains unresolved, you may contact the ADA Coordinator at the California Managed Risk Medical Insurance Board in Sacramento. See the Americans with Disabilities Act Compliance Statement below for how to contact the Board.

The Americans with Disabilities Act of 1990 (ADA)

Section 506 of the Rehabilitation Act of 1973 states that no qualified disabled person shall, on the basis of disability, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives or benefits from federal financial assistance.

California Government Code Section 11135 prohibits discrimination in a program or activity funded directly by the state or that receives financial assistance from the state on the basis of ethnic group identification, religion, age, sex, color or disability.

California Government Code Section 11136 requires state agencies, as described above, to notify a contractor whom they have reasonable cause to believe has violated the provisions of Section 11135 or any regulation adopted to implement such section.

After considering all relevant evidence, the Executive Director of the Managed Risk Medical Insurance Board may request a hearing to determine whether a violation has occurred.

The Americans with Disabilities Act of 1990 (ADA) prohibits the Managed Risk Medical Insurance Board and its contractors from discrimination on the basis of disability. The Act protects its applicants and enrollees with disabilities in program services. It also requires the Board and its contractors to make reasonable accommodations to applicants and enrollees that do not pose undue hardship on the Board or its contractors.

The Managed Risk Medical Insurance Board has designated an ADA Coordinator. This person will carry out the Board's responsibilities under the Act. You may have questions or concerns about Americans with Disabilities Act compliance by the Board or its contractors. If so, contact the Coordinator at:

ADA Coordinator
Managed Risk Medical Insurance Board
P.O. BOX 2769
Sacramento, CA 9581 2-2769
1 (916) 324-4695
The hearing impaired should call the California Relay Service at:
1 (800) 735-2929

Organ Donations

Any individual at least 15 years of age or older and of sound mind may give all or any part of her/his body as an anatomical gift. A person between 15-18 years old is required to have written consent of a parent or guardian. The gift may be made to a specified donee or without a specified donee. The gift of all or part of the body may be made by will or a document signed by the person or made by his telegraphic, recorded telephonic or recorded message. The gift may be made, changed or canceled by an oral statement made by means of a tape recording in the donor's own voice.

If you wish to become an organ or tissue donor, the California Department of Motor Vehicles (DMV) can supply a donor card that is carried with your driver license or California identification (ID) card and a donor sticker to be placed on the front of your driver license or ID card. It is important that organ donors share their decision with family members. If you need further information or would like to obtain a consent form, contact your Primary Care Provider at the clinic where you obtain care or contact the Plan's Medical Administration Department at 1 (626) 299-5539.

GLOSSARY OF WORDS AND TERMS

There are health care words and terms which can sometimes be confusing. Below we have provided the meaning of some of the words and terms. Contact the Plan's Member Services Department, at 1 (800) 475-5550, if you need more information regarding these conditions.

Definitions:

Anniversary Date: The day each year that corresponds to the day and month a person's coverage began in the Program.

Applicant: A person age 18 or over who is a parent,; a legal guardian; or a caretaker relative, foster parent, or stepparent with whom the child resides, who applies for coverage under the Program on behalf of a child. Applicant also means a person who is applying for coverage on his or her own behalf who is 18 years of age, or an emancipated minor; or a minor not living in the home of a parent, a legal guardian, caretaker relative, foster parent, or stepparent. An applicant also is a minor shi is applying for coverage on behalf of his or her child or a person who is age 19 or over and who is applying for coverage on his or her own behalf and/or that of another child-linked adult.

Benefit Year: The twelve (12) month period commencing July 1st of each year at 12:01 a.m.

Caretaker Relative: A relative who provides care and supervision to a child if there is no parent living in the home. The caretaker relatives may be any relation by blood, marriage, or adoption.

***Clinical trial*:** A research study with cancer patients, to find out if a new cancer treatment or drug is safe and works with the type of cancer that you have.

Copayment: The fee(s) paid by the Subscriber for certain covered services provided by the Community Health Plan. All required Copayments are specified in this Combined Evidence of Coverage and Disclosure and the Plan Contract.

Coverage Decision: The approval or denial of health care services by the health plan, or by one of its contracting providers that is based on a finding that the service is a covered or noncovered benefit.

Covered Services: Medical, hospital, mental health, and ancillary services provided by the Plan, either directly or through contracts with other providers of services.

Curative: Having the ability to cure or heal.

Disenrollment: The process by which you are no longer a Subscriber of the Community Health Plan.

Disputed Health Care Service: Any health care service that is acceptable as a covered benefit which has been denied, changed, or delayed by a decision of the health plan, or by one of its

contracting providers, in whole or in part due to a finding that the service is not medically necessary.

Emergency Services: Services provided for members who present with conditions that are manifested by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention may result in placing the health of the individual or unborn child in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily organ or part. Emergency services also include care for an emergency psychiatric condition.

Enrollment: The process by which you become a Subscriber of the Community Health Plan.

Extended Care: Full-time intermediate (sub-acute and transitional inpatient) care, skilled nursing, and related health care services to patients provided as part of an on-going therapeutic regimen.

Family Child Contributions: The monthly cost to an Applicant The Family Contribution does not include Copayments for services.

Family Parent Contributions: The monthly cost to an applicant to enable a subscriber parent or subscriber parents to participate in the program. Family parent contributions do not include copayments for services.

Family Contribution Sponsor: Is a person or entity that is registered with the Board and that pays the family child contributions and/or family parent contributions on behalf of an applicant for any twelve (12) consecutive months of the subscriber child or subscriber parent's participation in the program. A family contribution sponsor may sponsor a subscriber parent linked to a subscriber child enrolled in the program if the subscriber child is sponsor.

Life Threatening: Diseases or conditions where the likelihood of death is high unless the course of the disease is stopped and/or diseases or conditions that are likely to have possible deadly outcomes, where the goal of treating the conditions is lifesavings.

Medical Services: Those medically necessary professional health care services including medical, surgical, diagnostic, therapeutic and preventive services.

Member Services: The Plan office or staff which will assist Subscribers with Plan related questions or Grievances.

Open Enrollment Period: A period defined by the Healthy Families Program when eligible Subscribers may enroll in a health Plan.

Out-of-Plan: Those medical services provided to a Subscriber by a doctor, clinic, hospital or other medical services provider who:

a. Is not a Community Health Plan provider or Plan contract provider, or
b. Has not received a written referral to provide the services to the Subscriber.

Plan: The Community Health Plan.

Plan Contract: The agreement between the Healthy Families Program and the Community Health Plan regarding the terms and conditions of coverage.

Primary Care Provider: The Plan provider responsible for providing you with primary medical care, referring you to other specialist doctors, when necessary, and making sure that you have the proper follow-up care.

Program: The Healthy Families Program.

Serious Debilitating Illness: Diseases or conditions that cause permanent illness.

Services Area: The geographic area of all of Los Angeles County.

Standing Referral: A referral by your primary care doctor to a specialist for more than one visit to the specialist, as indicated in your treatment plan, without primary doctor having to provide a specific referral for each visit.

Subscriber: Either a subscriber child or a subscriber parent.

Subscriber Child: Is a person age 18 or a child who is eligible for and participates in the program.